**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name and Address**

COLUMBIA RIO GRANDE REGIONAL
HOSPITAL
C/O DAVIS FULLER JACKSON KEENE
11044 RESEARCH BLVD STE A-425
AUSTIN TX 78759

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**Carrier's Austin Representative Box**

Box Number 54

**MFDR Tracking Number**

M4-98-A958-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The provider submitted the billing for the same and received a payment from TWCIF, the carrier, in the amount of $3,300.00." "First the per diem rates contained in the guidelines for inpatient acute care have been held to be void and unenforceable by the Supreme Court of Texas." "In light of the above, the provider asserts it is owed the full amount of the bill, which is fair and reasonable. At the least the carrier owes 80% of the total charges pursuant to the 'old law'."

**Amount in Dispute:** $7046.44

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "…The Fund also contends that Petitioner's evidence fails to meet Petitioner's burden of proof to establish by a preponderance of the credible evidence that the Funds' reimbursement methodology falls short of the statutory standards for payment set forth above…Further, independent evidence established that the payment method used by the Fund provides payment to hospitals that equaled or exceeded the payment levels set in the statutory standards."

**Response Submitted by:** TWCIF, 221 West 6th Street, Suite 300, Austin, TX 78701-3403

## *SUMMARY OF FINDINGS*

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| September 2, 1997 through September 5, 1997 | Inpatient Hospital Services | $7046.44 | $54.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the reimbursement guidelines for inpatient hospital services.
3. This request for medical fee dispute resolution was received by the Division on April 16, 1998.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - M-Reimbursed according to fair and reasonable standards.

**Findings**

1. This dispute relates to inpatient medical services provided in a hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.401.
2. 28 Texas Administrative Code §134.401(b)(1)(B), states "Inpatient Services – Health care, as defined by the Texas Labor Code §401.011(10), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital."

   A review of the submitted medical bill and itemized statement, indicate that the requestor billed for three (3) inpatient surgical day; therefore, this admission meets the definition of inpatient services per 28 Texas Administrative Code §134.401(b)(1)(B).
3. 28 Texas Administrative Code §134.401(c)(1) states "Standard Per Diem Amount. The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Surgical $1,118."
4. 28 Texas Administrative Code §134.401(c)(3)(B), the reimbursement calculation formula is "LOS X SPDA = WCRA." Therefore, 3 days multiplied by $1,118.00 = $3,354.00.

   A review of the submitted explanation of benefits supports reimbursement of $3300.00 was made for the inpatient surgical services. The difference between the per diem rate of $3,354.00 and amount paid of $3,300.00 is $54.00.
5. 28 Texas Administrative Code §134.401(c)(4), states "Additional reimbursement. All items listed in this paragraph shall be reimbursed in additional to the normal per diem based reimbursement system in accordance with the guidelines established by this section. Additional reimbursement apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section."
6. 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."

   A review of the submitted medical bill indicates that the requestor billed revenue code 278 for implantables. The requestor submitted a copy of the Implantable Device Tracking Report that supports implantables were used; however, the requestor did not submit cost invoices to support position that additional reimbursement is due; therefore, reimbursement cannot be recommended for implantables.

   The requestor supported position that additional reimbursement of $54.00 is due for inpatient services.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports additional reimbursement of $54.00 is due the requestor. As a result, the amount ordered is $54.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $54.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803 due within 30 days of receipt of this Order

**Authorized Signature**

| | | |
|---|---|---|
| | | 11/16/2011 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO REQUEST AN APPEAL*

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.